Midlothian Integration Joint Board

Annual Performance Report

2025/26

Contents

Executive Summary

The Midlothian Integration Joint Board (IJB) plans and directs health and social care services for the people of Midlothian. We are a planning and decision-making body responsible for the integrated budget from Midlothian Council and NHS Lothian.

This section will be updated prior to publication in August 2026.

Foreword

Welcome to our 11th Annual Performance Report which reflects on our progress and performance from 1st April 2025 to 31st March 2026.

This section will be updated prior to publication in August 2026.

Morag Barrow

Chief Officer, Midlothian IJB

Introduction

Who we are

The Midlothian Integration Joint Board (IJB) plan and direct health and social care services for the people of Midlothian. We are a planning and decision-making body created by Midlothian Council and NHS Lothian. We are responsible for an integrated budget that we receive from Midlothian Council and NHS Lothian. The priorities set out in our Strategic Plan guide how we allocate the money we receive.

Our responsibilities and legal duties are outlined in the Public Bodies (Joint Working) (Scotland) Act (2014). We meet regularly and include members from NHS Lothian and Midlothian Council, the Third Sector, staff, and people who represent the interests of people and communities, people who experience our services, their families, and carers.

Midlothian Health and Social Care Partnership oversees more than 60 services on our behalf. This includes two hosted services, Dietetics and Adults with Complex and Exceptional Needs, who deliver care to people across the whole Lothian region for the four Health and Social Care Partnerships - Midlothian, East Lothian, West Lothian, and City of Edinburgh.

WE PLAN HEALTH & CARE SERVICES FOR

99,880

PEOPLE IN THEIR HOMES, IN THE COMMUNITY & IN HOSPITALS

OUR SERVICES INCLUDE:

ADULT SOCIAL CARE	CARE HOMES	A&E	COMMUNITY HOSPITAL
DAY SERVICES	END OF LIFE CARE	VACCINATIONS	ALLIED HEALTH PROFESSIONALS
CARE AT HOME	JUSTICE	MENTAL HEALTH	COMMUNITY NURSES
SUPPORT FOR CARERS	AIDS & ADAPTATIONS	PRIMARY CARE	REHAB & RECOVERY

What we are trying to achieve

The Scottish Government measure our performance on Health and Wellbeing Outcomes.

	National Health & Wellbeing Outcome	
1		**Health & Wellbeing** People are able to look after and improve their health and wellbeing and live in good health for longer.
2		**Living in the Community** People are able to live, as much as possible, independently and at home or in a homely setting in their community.
3		**Positive Experiences & Dignity** People who use health & social care services have positive experiences of those services, and have their dignity respected
4		**Quality of Life** Health & social care services help to maintain or improve the quality of life of people who use those.
5		**Health Inequalities** Health & social care services contribute to reducing health inequalities.
6		**Support for Carers** People who provide unpaid care are supported to look after their health and wellbeing.
7		**Safe from Harm** People using health & social care services are safe from harm.
8		**Workforce** Staff are engaged with their work and are supported to continuously improve the information, support, care, and treatment they provide.
9		**Use of Resources** Resources are used effectively and efficiently.

We also measure our performance against the objectives in our Strategic Plan.

Our Strategic Plan 2025-2035 has three main aims and six sub-aims:

1. **People are able to make good decisions that help them stay well, plan ahead, and prevent ill or worsening health**
   - 1.1 People can easily find the information they need to make good decisions.
   - 1.2 People achieve the things that matter most to them, and our services are confident of what our contribution is to their success.
   - 1.3 People access services and support designed around how they live their lives.

2. **People access the care and support they need when they need it in the community and at home**
   - 2.1 People easily access the services that help them stay well, independent, and active.
   - 2.2 People have access to services in their own community.
   - 2.3 People are living in the place of their choosing for longer.

3. **People's human, social, and economic rights are protected and promoted in how we design our services**
   - 3.1 People are recognised as experts in their own lives, are involved in planning services, and feel valued.
   - 3.2 People's care and support adapts when their needs, choices and decisions change and can control their own care and support if this is what they want.
   - 3.3 People benefit from organisations working together and sharing information safely.

We recognise people are the experts in manging their own health and wellbeing and want to provide the right support, treatment, and care for people to live well in their homes and communities. We want services to be available when people need them and at every stage of their care and treatment:

- Preventing ill health and providing support early,
- Ongoing support and treatment,
- In times of crisis and emergency.

We think about how we work, and how we can improve, in three ways:

- **Integration** is about how we work with all our partners to ensure everyone gets the right care, at the right time, and in the right setting.
- **Quality** is about 6 key areas of services – are they safe, effective, efficient, timely, person-centred, equitable.
- **Best Value** is about ensuring resources are well managed improving services that deliver the best possible outcomes for people and communities.

How we measure our performance

Our contribution to people's outcomes

The services we plan and direct must, by law, aim to improve outcomes for people who use our services, their carers, and families. Many factors influence peoples' lives, and it can be hard to know the impact of each service or support we offer.

To ensure that we understand the impact of our work, we use an approach called Outcome Mapping. This is a way to understand how our services contribute to people achieving the outcomes that matter to them. It can also help us make more targeted, locally informed decisions about how to plan and direct services. This approach allows us to describe what we do, who with, what people learn and gain as a result, how this makes them feel and the difference this makes to their lives.

The data we use

- **Scottish Government's Ministerial Strategic Group targets**

- **Scottish Government's National Performance Indicators**
  The National Indicators 1-9 are taken from the Health and Care Experience Survey, conducted every 2 years. 2025/26 is a reporting year for the Survey and changes are included in this Annual Performance Report.

  In November 2025 the survey was posted to a random sample of people living in Midlothian and registered with a GP in Scotland. People were asked about their experiences during the previous 12 months - accessing and using their GP practice and Out of Hours services; aspects of care and support provided by local authorities and other organisations; and caring responsibilities and related support.

  The Scottish Government updated the survey in 2023, (the changes are in the Scottish Government Technical Report). This means it is difficult to compare our performance with previous years, and in some cases, we only have data from 2020.

  This section will be updated in August following the publication of the HACE survey responses.

- **Feedback from people who use our services, their families, and carers**

  In early 2026, we carried out the Midlothian IJB Annual Survey by inviting people living in Midlothian to complete a questionnaire to share their views about health and social care. This section will be updated in August following the analysis of the Midlothian IJB Annual Survey.

- **iMatter survey for employees**
  This section will be updated in August following the release of the 2025/26 iMatter results. Staff are asked about their work and their wellbeing. The Employee Engagement Index (EEI) is the overall score for the organisation. The survey explores how staff feel they are:
  - Informed, trained & developed,
  - Involved in decisions,
  - Treated fairly and consistently, with dignity and respect, in an environment where diversity is valued,
  - Provided with a continuously improving and safe working environment, promoting the health and wellbeing of staff, patients, and the wider community.

- **Other Data**
  We use a range of other data sources in this report. Some of the data we use in this report covers elements of services that are delivered by GP independent contractors. We also use information from national organisations and professional bodies, e.g. National Records of Scotland, Public Health Scotland, and the Care Inspectorate.

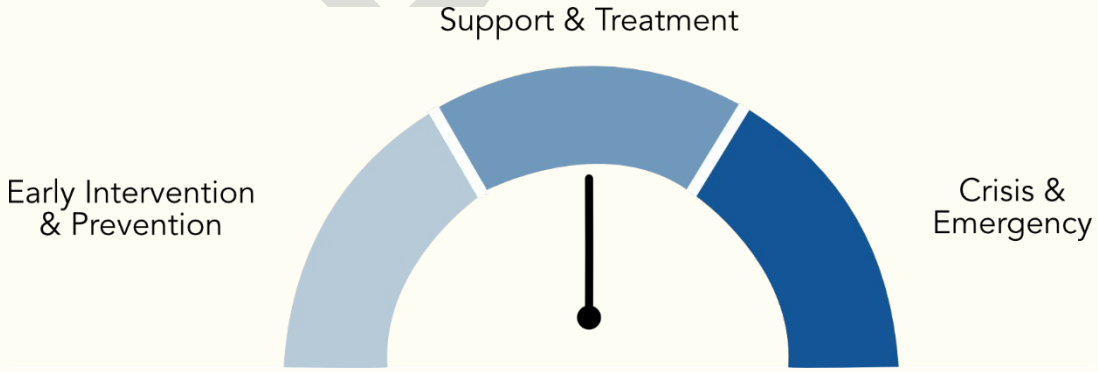
How we are reporting our data

Full data is provided in the Appendix. This includes our progress over time and our position in comparison to the rest of Scotland. We look at each of the Health and Wellbeing Outcomes alongside the National Performance Indicators used to measure each one and summarised our progress:

- Our performance has improved compared to last year.
- There hasn't been a significant change in performance compared to last year.
- Our performance has worsened compared to last year.

For each Health and Wellbeing Outcome we have described the impact of what we do. We have used icons to show if the impact was for Early Intervention and Prevention, Support and Treatment or Crisis and Emergency.

This report brings together information about our activity, experience, and outcomes across all the functions that are delegate to us to plan for and direct. This includes the two pan-Lothian hosted services that are managed by Midlothian Health and Social Care Partnership.



How did we do?

The National Indicators

	National Indicator	Our result	Our Progress
1	Adults are able to look after their health very well or quite well.		
2	Adults supported at home agreed that they are supported to live as independently as possible*.		
3	Adults supported at home agreed they had a say in how their help, care or support was provided*.		
4	Adults supported at home agreed that their health and social care services seemed to be well coordinated*.		
5	Adults receiving care or support rated it as excellent or good*.		
6	Adults had a positive experience of the care provided by their GP practice.		
7	Adults supported at home agreed services and support had an impact on improving or maintaining their quality of life*.		
8	Carers feel supported to continue in their caring role.		
9	Adults supported at home agreed they felt safe*.		

	National Indicator	Our result	Our Progress
 11	Premature Mortality Rate. (People under 75)		
 12	Emergency Admission Rate.		
 13	Emergency Bed Day Rate.		
 14	Readmission to hospital within 28 days.		
 15	Proportion of the last 6 months of life spent at home or a community setting.		
 16	Falls Rate (People over 65 who were admitted to hospital).		
 17	Care services graded Good or better in Care Inspectorate Inspections.		
 18	Adults with intensive care needs are receiving care at home.		
 19	The number of days people aged over 75 spend in hospital when they are ready to be discharged.		
 20	Health and Care resource spent on hospital stays where the person was admitted as an emergency.		

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1 Health & Wellbeing

People are able to look after and improve their health and wellbeing and live in good health for longer.

Scottish Government descriptors for this outcome

- I am supported to look after my own health and wellbeing
- I am able to live a healthy life for as long as possible
- I am able to access information

National Indicators used to measure this outcome

	National Indicator	Our result	Our Progress
1	Adults are able to look after their health very well or quite well.		
11	Premature Mortality Rate (People under 75)		
12	Emergency Admission Rate		

This section will be updated in August following the publication of the core suite of integration indicators and the analysis of the Midlothian IJB Annual Survey.

Indicator 1 is taken from the national Health and Care Excellence Survey (HACE), which is published every two years. As 2025/26 is a reporting year, this indicator has been updated from the 2023/24 data.

One of the ways we help people to access the information they need is to ensure it is visible and easy to understand. Throughout 2025/26 we have ensured our services design accessible and straightforward information on webpages, posters and leaflets to let people know about available services and supports. These included:

- a leaflet about support in the first year after someone leaves prison and returns to their local community,
- a leaflet with 'Diversion from Prosecution' information for those who may be able to undertake community treatment and avoid prosecution,
- a leaflet on how men in the Justice system can access emotional support,
- a new Community Justice section on the Midlothian Council website to help people navigate support and assistance,
- posters in GP surgeries that provide information on how to use asthma and COPD medicines,
- posters in GP surgeries to raise awareness of dementia and available support, and
- a Home Safety Guide for people with dementia, their family and carers.

The support we offer to people living with physical disabilities and long-term conditions can have a positive impact on their ability to look after their own health, but we know the barriers and challenges people experience are different for every person. It is important for people to have their circumstances assessed as quickly as possible and receive the right support to live in better health for longer. Throughout 2025/26, 93% of physical disability referral screenings were completed within the standard of 3 days, and 89% of interventions achieved the planned outcome. Partnering with other organisations can offer even more support for those with physical disabilities.

Midlothian's partnership with the Royal National Institute for Deaf (RNID)

Midlothian's Local Area Coordination Team work in partnership with a variety of organisations to build knowledge of local networks, strengthen community links and connect individuals to services that can offer support.

In 2025 the Local Area Coordinators met with the RNID Coordinator to discuss a new drop-in service to provide information on hearing loss and tinnitus, and support and services within their own area. They also provide mini hearing tests on-site, and basic hearing repairs.

The RNID Coordinator was connected to existing drop-in services at Café Connect at Dalkeith Art Centre and Linking Loanhead at Loanhead Library to meet local people experiencing hearing loss and learn more on what support people in Midlothian need. Plans are underway to further develop these drop-in services and offer more locations to better support people in different areas of Midlothian.

2 Living in the Community

People are able to live, as much as possible, independently and at home or in a homely setting in their community.

Scottish Government descriptors for this outcome

- I am able to live as independently as possible for as long as I wish
- Community based services are available to me
- I can engage and participate in my community

National Indicators used to measure this outcome

	National Indicator	Our result	Our Progress
2	Adults supported at home agreed that they are supported to live as independently as possible.		
3	Adults supported at home agreed they had a say in how their help, care or support was provided.		
12	Emergency Admission Rate.		
13	Emergency Bed Day Rate.		
14	Readmission to hospital within 28 days.		
15	Proportion of the last 6 months of life spent at home or a community setting.		
16	Falls Rate (People over 65 admitted to hospital as an emergency).		
18	Adults with intensive care needs are receiving care at home.		

	National Indicator	Our result	Our Progress
19	The number of days people aged over 75 spend in hospital when they are ready to be discharged.		
20	Health and Care resource spent on hospital stays where the person was admitted as an emergency.		

This section will be updated in August following the publication of the core suite of integration indicators and the analysis of the Midlothian IJB Annual Survey.

Indicators 2 and 3 are taken from the national Health and Care Excellence Survey (HACE), which is published every two years. As 2025/26 is a reporting year, these indicators have been updated from the 2023/24 data.

We know that circumstances can change, and people may find that they need additional support. The Care at Home teams delivered an average of 9000 hours of care and support in people's homes every week throughout 2025/26. During 2025 our external providers worked to improve consistency of care and focused on increasing staff retention. This means people were more likely to be supported by the same carers and develop a long-term relationship.

When people need more support, the Highbank Intermediate Care Unit provides bed-based care. As part of our plan to review and redesign our bed-based care, residents at our Highbank Intermediate Care Facility will move to a new unit at Polton Street. This facility has been designed to provide placements to progress assessments for rehabilitation, packages of care, or care home placement, to ensure people do not have to stay in hospital longer than they need to. Social Workers have a key role in supporting people receive the right support and reduce hospital delays by supporting admissions and discharge planning.

For people with dementia, delivering support in a coordinated way can help people live in their community for as long as possible. Social Workers in the Dementia Team continue to focus on the outcomes that matter most to people, support people to stay at home for longer, and provide assessment for long-term care if this is required. Throughout 2025/26, Social Workers attended dementia café groups to ensure we keep listening to people and better understand how we can continually improve the quality of the care we provide.

When people's needs become more complex, residential care may be required to provide the right care. However, there continues to be a shortage of available care home places in Midlothian. To address this, quality assessments are undertaken to help us improve how we communicate with people, their families and carers, and increase the availability of additional clinical support when moving from an acute hospital to intermediate or longer-term care placement. 95% of initial Care Home reviews were completed within the 12-week standard throughout 2025/26.

Art therapy at Newbyres

We know that how people feel about their environment is important to their sense of wellbeing and belonging. In March 2026 Newbyres Care Village worked with a local artist and former member of staff to decorate a linking corridor with a garden-inspired mural.

The 'garden corridor' has been brought to life with 3D foliage, butterflies, and a working lantern with plans for chairs and background nature sounds. Residents can now enjoy the outdoors no matter the weather and visiting friends and relatives have described the initiative as "wonderful".

Cycling to success

Cycling UK is a registered charity that works with local councils and services through their Connecting Communities programme to help residents own their own bikes, discover local cycling routes, build confidence while riding, and find practical alternatives to car journeys. In Midlothian, Cycling UK has been working with our commissioned partner, VOCAL, and since July 2025 planning new walking, cycling and wheeling routes around Shawfair and Auchendinny to better connect new housing developments with surrounding towns and villages. People in Midlothian who engaged with Cycling UK reported they get more exercise, use their car less, and feel safer when cycling.

> "We will now use the bike for trips to the shop and nursery instead of the car. We are looking forward to further cycle infrastructure to make even more journeys by bike."

Providing information and delivering care in community settings can help people live independently by increasing access to services in their local area. We know that when services are provided in local areas, people find it easier to attend because travel time and costs can be reduced.

Care closer to home

The Orthopaedic Rehabilitation Clinic supports people with musculoskeletal and orthopaedic conditions through a range of physiotherapy sessions and group classes.

In 2025, 89 rehabilitation appointments were offered at Midlothian Community Hospital instead of the Royal Infirmary of Edinburgh. This gave people the option to attend appointments closer to home and saved 145.67 miles in travel. Holding these appointments locally made best use of local rehabilitation facilities and provided opportunities for training and knowledge sharing within our Musculoskeletal Physiotherapy Team.

This success has led to the Pulmonary Rehabilitation service in Midlothian planning two new classes at Midlothian Community Hospital. This will help manage growing demand and local waiting times and improve outcomes after surgery.

One stop shop for falls prevention

220 people attended a Community Engagement Day on Falls Prevention on September 25th at the Lasswade Centre. Throughout the day, 103 people completed an MOT during the session, which assessed people's 'sit to stand' ability and their core strength. All attendees received signposting to further support and advice. This included information on falls prevention and recovery, frailty, and overall bone health.

This community-based multidisciplinary event aimed to prevent or reduce falls and injury, hospital admission, loss of physical activity, reduced confidence, and social isolation.

"Good variety of stalls with helpful info. I was able to have questions answered and advice given to take away."

"The personal fitness MOT was an excellent activity to see where I am compared to average for my age."

Feedback from the day was very positive and another Community Engagement Day was held in April 2026.

We are committed to transforming the delivery of palliative and end of life care by June 2026. This work is linked to the Pan Lothian commissioning of Specialist Palliative Care services and the updated national Palliative Care Strategy Delivery Plan 2025. As part of this work, we have asked Midlothian Health and Social Care Partnership to ensure people can access co-ordinated, timely and high-quality palliative care, care around death, and bereavement support based on their needs and preferences. We want to ensure there is support for families and carers as they deal with loss and grief, and for staff to manage the emotional impact of caring for someone at the end of life.

3 Positive Experiences & Dignity

People who use health & social care services have positive experiences of those services, and have their dignity respected

Scottish Government descriptors for this outcome

- I have my privacy respected
- I have positive experiences of services
- I feel that my views are listened to
- I feel that I am treated as a person by the people doing the work - we develop a relationship that helps us to work well together
- Services and support are reliable and respond to what I say.

National Indicators used to measure this outcome

	National Indicator	Our result	Our Progress
3	Adults supported at home agreed they had a say in how their help, care or support was provided.		
4	Adults supported at home agreed that their health and social care services seemed to be well coordinated.		
5	Adults receiving care or support rated it as excellent or good.		
6	Adults had a positive experience of the care provided by their GP practice.		
14	Readmission to hospital within 28 days.		
15	Proportion of the last 6 months of life spent at home or a community setting.		
19	The number of days people aged over 75 spend in hospital when they are ready to be discharged.		

Indicators 3, 4, 5 and 6 are taken from the national Health and Care Excellence Survey (HACE), which is published every two years. As 2025/26 is a reporting year, these indicators have been updated from the 2023/24 data.

This section will be updated in August following the publication of the core suite of integration indicators and the analysis of the Midlothian IJB Annual Survey

GP Practices are often the first place people go to get support with their health and wellbeing. Practices located near each other belong to a 'GP cluster' which contributes to the oversight and development of local healthcare and takes part in quality improvement activity. Midlothian GP cluster quality improvement initiatives have focused on improving access to timely, effective care and supporting patient safety.

Electronic reviews for Hormone Replacement Therapy (HRT)
Dalkeith and Pathhead GP practices in Midlothian upgraded their websites to allow patients to complete and submit their annual HRT review forms electronically, without needing to attend an appointment. This resulted in between 80-90% less appointments being needed at both practices. Similar electronic reviews are planned for contraceptive, ADHD, and depression medications.

Community services aim to provide treatment, care, and support as close to home as possible. However, some treatment can only be provided in a hospital setting. People told us that when they needed emergency care, they were having to wait longer in A&E, staying longer in hospital, and sometimes being delayed when leaving hospital for home. NHS Lothian developed their Unscheduled Care Improvement Plan to improve people's experience within a hospital setting. In Midlothian, this has focused on supporting people to come home more quickly by supporting more care in community settings.

Getting home sooner

30% of all unplanned hospital admissions for Midlothian residents to the Royal Infirmary of Edinburgh are people aged 75 and over. The work in Midlothian to reduce the length of time people spent in hospital saw the length of stay in hospital reduce by almost a week for this age group. This is the equivalent of approximately 20, 000 bed days that were saved across Midlothian in 2025, by ensuring that people were well enough to go home safely, as soon as possible.

When people are discharged from hospital, they sometimes need to be readmitted for further care. Readmission rates to hospital are often used to evaluate how well we plan and support discharge. Our local data show that readmission rates for 2025/26 for people living in Midlothian improved when compared with 2024/25. The readmission rate after 6 months reduced from 23% to 19%, and after 28 days reduced from 11% to 10%. The readmission rate after 7 days remained stable at 4% throughout 2025/26.

Digital solutions

FLOK Health is an AI platform that offers advice and exercises for treating lower back pain. It has been tested by health care professionals across Lothian and signposting and advertising has been exhibited in GP practices across Midlothian. FLOK assesses a person's symptoms and develops an individual 12-week program with exercises and advice on how to manage pain. Data returned between August and November 2025 showed that after six months of using FLOK, 80% of people did not need to return to primary care, their GP or the MSK service for further treatment. This shows the effectiveness of FLOK in helping people to better manage their health without needing face to face appointments. Other services in Midlothian are now considering digital platforms to support people to self-manage their symptoms and conditions.

We continued to work with our commissioned partners to ensure adults with learning disabilities in Midlothian have the opportunity to build practical skills, gain confidence in their abilities, and feel proud of their achievements. 92% of care package reviews for people with a learning disability had been completed within the 2-year standard throughout 2025/26. Garvald Edinburgh provides day services to adults with learning disabilities in Midlothian. The service offers opportunities to build

skills, pride, and confidence through experiences with cooking, gardening, pottery, textiles, jewellery, art, and printmaking. Activities to improve physical and mental health and wellbeing are also offered, including walking and swimming groups, music and dance, and meditation.

We know that working with people and developing relationships is the best way to support people to achieve what matters to them. In 2025/26 we worked alongside the charity Access to Industry to support people in Midlothian to return to work. Access to Industry is a registered Charity with specialist skills to support unemployed people across Scotland who face barriers to employment. In 2025/26, Access to Industry supported 57 people across four different projects at local libraries, community centres, and recovery cafes across Midlothian as well as the Learning Hub in Hardengreen. Classes and groups promoted the benefits of connection and routine with Personal Learning and Development Action Plans created for each person to help them achieve their goals. Throughout 2025/26 the cohort achieved 34 new qualifications and resulted in 5 participants moving into employment, 15 entering further education at Edinburgh and Newbattle Abbey Colleges, 6 taking up volunteer roles, 1 entering the SDF Addiction Workers Programme, and 13 undertaking residential rehabilitation and aftercare support.

Support to achieve what matters to you

Access to Industry supported a local young adult who was experiencing anxiety and low confidence to get back into work. Through weekly sessions, Access to Industry provided tailored support to help the person develop strong working relationships with staff that supported them to become more confident and motivated. As a result, they studied for and passed their driving theory and soon took up a college place in Edinburgh. In summer 2025 Access to Industry recognised the young adult's achievement with a local award, noting they are thriving and looking forward to continuing their college education.

4 Quality of Life

Health & social care services help to maintain or improve the quality of life of people who use those.

Scottish Government descriptors for this outcome

- I'm supported to do the things that matter most to me
- Services and support help me to reduce the symptoms that I am concerned about
- I feel that the services I am using are continuously improving
- The services I use improve my quality of life.

National Indicators used to measure this outcome

	National Indicator	Our result	Our Progress
5	Adults receiving care or support rated it as excellent or good.		
7	Adults supported at home agreed services and support had an impact on improving or maintaining their quality of life.		
13	Emergency Bed Day Rate		
14	Readmission to hospital within 28 days		
16	Falls Rate (People over 65)		
19	The number of days people aged over 75 spend in hospital when they are ready to be discharged.		
20	Health and Care resource spent on hospital stays where the person was admitted as an emergency.		

Indicators 5 and 7 are taken from the national Health and Care Excellence Survey (HACE), which is published every two years. As 2025/26 is a reporting year, these indicators have been updated from the 2023/24 data.

This section will be updated in August following the publication of the core suite of integration indicators and the analysis of the Midlothian IJB Annual Survey.

We have continued to support people in Midlothian to make positive changes, improve their quality of life, and achieve the outcomes that matter to them. One example of this is unpaid work. Organised through the Justice service, unpaid work aims to provide opportunities that also benefit the community e.g. gardening, house clearing, and maintenance.

44% of residents who were helped by those undertaking unpaid work throughout 2025/26 told us about their positive experience.

> "This has saved me fines when I leave the property that I wouldn't be able to pay on my pension."

> "Without this help I wouldn't be able to get out of hospital."

Midlothian Health and Social Care Partnership's services are trauma-informed because we know that exposure to trauma can impact on neurological, biological, psychological and social development. Trauma-informed practice is an approach to health and care interventions that ensures a person-centred approach by focusing on safety, trust and choice. Services and supports should help people to do the things that matter most to them. People who were subject to a Community Payback Order in 2025/26 told us it is important to them to improve their mental health, build a routine, avoid boredom, improve finances, and change their alcohol and drug use. The Community Justice service team asked the people they worked with about the improvements they saw in their lives:

- mental health (67%)
- build a routine and avoid boredom (50%)
- financial position (50%)
- positive change to alcohol and drug use (33%).

Everyone supported by the Justice Social Work service is asked to complete a questionnaire at the beginning and end of their support. When the exit questionnaires were completed, 100% of people reported that they felt listened to, and the majority thought the service had helped them to maintain or improve their quality of life. Most people rated the service they received as good or excellent based on their experience of relationship and trust with our teams, as well as the care and support provided.

Midlothian Substance Use Service brings together nurses, doctors, social workers and psychologists to provide assessment, care and treatment of people who use alcohol and/or drugs. The service supports people both at home and in the community to make positive changes to their

lives. When people have the support they need, we know this leads to better outcomes. Throughout 2025/26, the service continued to achieve the 90% target to meet the 21-day standard from referral to treatment.

In additional to one-to-one appointments, the Midlothian Substance Use Service provides information on mental health, coping skills, and advice on benefits and financial support available. Further assistance is offered through the Horizons recovery café, where people who are in recovery can speak to the Citizen's Advice Bureau on matters such as Universal Credit, debt relief, housing and council tax. Horizons is open every Monday and Friday and between 30 – 60 people attended each day throughout 2025/26.

5 Health Inequalities

Health & social care services contribute to reducing health inequalities

Scottish Government descriptors for this outcome

- My local community gets the support and information it needs to be a safe and healthy place
- Support and services are available to me
- My individual circumstances are taken into account

National Indicators used to measure this outcome

	National Indicator	Our result	Our Progress
11	Premature Mortality Rate (People under 75)		
12	Emergency Admission Rate		

Health inequalities among older people in Scotland are influenced by a complex mix of social, economic, and health related factors. The Scottish Index of Multiple Deprivation (SIMD) is how the Scottish Government identifies deprivation in Scotland. SIMD data is organised into 10 data zones, from the most to the least deprived. In Midlothian, 8.5% of the population live in a zone that is considered to be the most deprived, and 13.6% live in a zone that is considered to be the least deprived.

According to the Scottish Burden of Disease study, by 2044, Scotland is projected to see:

- 63% increase in chronic obstructive pulmonary disease (COPD)
- 56% increase in atrial fibrillation
- 36% increase in both diabetes and stroke.

Our local data over the last three years also tell us that people aged 75 and over are only a small number of attendances at A&E but often spend much longer there than younger age groups. 64% of people living in Midlothian who are aged 65 – 74 have a long-term condition. This rises to 84% for those aged 85 and over, which means older people often need more time for the right assessment, treatment, and care. The three most common long-term conditions in people aged 65 and over living in Midlothian are arthritis, cancer, and coronary heart disease.

The number of older people in Scotland living with long-term health conditions is increasing and this impacts on health inequalities over a lifetime. Older adults in more deprived areas of Scotland tend to experience shorter life expectancy, more years lived in poor health, and higher rates of hospital admissions and chronic conditions. Our experiences in early life including poverty, poor housing, limited access to education, and unhealthy working conditions have a significant impact on our future.

We want everyone to live good lives, for longer. To reduce health inequalities that can be experienced by older people, we are working across the system to continually improve the care and support we provide. Our local data told us that older adults are more likely to be admitted to hospital than other age groups, and people aged 75 and over were more likely to experience a delay to their discharge. We took a targeted approach in 2025/26 to implement new ways of working designed to reduce the time people spend in hospital, especially when they are medically ready to return home.

Our local data for attendances at the Royal Infirmary of Edinburgh's Emergency Department (ED) show some age-related variation. People from Midlothian aged 75+ accounted for 18% attendances. This change in age profile will continue to be monitored as part of the work to support the NHS Lothian Unscheduled Care Improvement Programme.

The contributions from teams across health and social care have improved the experience of hospital admission and discharge throughout 2025/26 for all age groups, with the most significant reduction in delayed discharges being achieved for the 75 and over age group. We will continue to monitor this data, to ensure the positive impact in reduction of health inequalities is sustained in the longer term.

The Older People's Social Work Team provide social work assessment, care management and a review of services for people over 65 years old and their carers. In order to ensure residents are receiving the best possible care, we are working collaboratively with care homes on a range of topics including resident experience, care planning, medicine management, falls management, recruitment and retention and staff wellbeing. A Care Inspectorate report in January 2026 found that staff at Newbyres Care Village were knowledgeable about people's care needs, showed genuine care and respect when supporting people, and that the people who lived at Newbyres and their families were happy with the care provided.

The In Reach Social Work Team are a key service that ensure people are given the right support to return home as quickly as possible. The team provide assessment and discharge planning for people who live in Midlothian and have been admitted to one of five hospital sites or the Highbank Intermediate Care Unit. Throughout 2025/26 the team received approximately 750 referrals. The average number of people experiencing a delay to their discharge from hospital for a social reason reduced from 8.4 to 5.7.

People living with obesity can experience weight stigma and face a combination of physical and social barriers to accessing healthcare. The Public Health Practitioner team spoke to people living

with obesity in Midlothian and 80% reported that the felt stigmatised in a healthcare setting. In response to these discussions, the team developed and delivered training to increase the awareness of Weight Bias, and to give staff and volunteers the knowledge, skills and confidence to have positive, constructive conversations with people about their weight. This work has challenged attitudes, behaviour and environments, and reduced barriers for people who are overweight or obese to talk openly about their weight without feeling stigmatised. 19 sessions were offered throughout 2025/26 with over 193 participants. 63 evaluations of the training were returned and feedback showed that staff would recommend the training to others.

"I think this has raised my awareness in terms of language to use when discussing weight. It highlighted the importance of checking with patients first whether this is an area they want to discuss or not."

"It made me challenge my thoughts more on why I was hesitant when addressing the subject, when I wouldn't hesitate to address a heart condition for example. Made me rethink my tone, body language and generally language used whilst approaching patients."

We know that good sexual health is important for overall health and well-being and can impact couples, families, and the social and economic development of communities. Inequalities in care can lead to higher risks of Sexually Transmitted Infections (STIs) and unintended pregnancies. Support with sexual health, and access to services that provide information and advice, can help people make good decisions for their treatment options. 'No.11' in Dalkeith houses a range of integrated services including Mental Health, Substance Use, Justice Services, and the Third Sector. The team at No. 11 are working in partnership with Chalmers Sexual Health Centre and Midlothian Health and Social Care Partnership's Health Inclusion Team to support people with their sexual health and wellbeing. Sexual health advice and support appointments, including STI testing and treatment, are offered each month to vulnerable adults affected by homelessness, criminal justice, mental health and/or substance use issues. Sexual health training is offered to all staff based at No. 11 as part of the Homeless Outreach Support Service run by the Health Inclusion Team. Educational materials on long-acting contraception, and stocks of pregnancy tests and condoms are available in the building and are free to all.

6 Support for Carers

People who provide unpaid care are supported to look after their health and wellbeing.

Scottish Government descriptors for this outcome

- I feel I get the support I need to keep on with my caring role for as long as I want to do that
- I am happy with the quality of my life and the life of the person I care for
- I can look after my own health and wellbeing

National Indicators used to measure this outcome

	National Indicator	Our result	Our Progress
8	Carers feel supported to continue in their caring role.		

Indicator 8 is taken from the national Health and Care Excellence Survey (HACE), which is published every two years. As 2025/26 is a reporting year, this indicator has been updated from the 2023/24 data.

This section will be updated in August following the publication of the core suite of integration indicators and the analysis of the Midlothian IJB Annual Survey.

Understanding the experience of carers in Midlothian is vital to ensure we design and deliver services and support that carers need. All carers are entitled to a personalised plan or statement that outlines their needs as a carer and the support they will receive. Adult Carer Support Plans are developed alongside carers to ensure their voice is heard and their views are reflected. Throughout 2025/26, 98 Adult Carer Support Plans were completed by the Midlothian Health and Social Care Partnership with an additional 1281 offered and 921 completed by our commissioned partner, VOCAL. VOCAL supports unpaid carers in Midlothian through a range of services for adult carers who are caring for family members or friends with physical disabilities, mental health conditions, alcohol and drug use.

Our Unpaid Carer Strategy 2025-2028 sets out the action we will take over the next three years to improve the experience of carers in Midlothian. We approved Our Unpaid Carer Strategy in February 2026. Due to the joint approach with Midlothian Council Children's Services we published this plan in May 2026 following Midlothian Council approval of the element relating to Young Carers.

This strategy was developed in collaboration with the Health and Social Care Partnership's Carers Planning Group and Third Sector partners, and in consultation with unpaid carers across Midlothian. Our Unpaid Carer Strategy is a central part of how we will make progress towards our strategic aims and identifies the priority themes and actions we will take to support local carers such as: Carer Rights and Identification; Providing Information, Advice and Support; Providing Carer Economic Wellbeing; Supporting Health and Wellbeing (including breaks from caring); Supporting Carer Involvement in Care Planning.

Caring for another person can have a significant impact on a carer's health and wellbeing. People will not always identify themselves as a carer, so VOCAL hold monthly 'Think Carer' sessions that provide training for professionals to help them support unpaid carers they come into contact with. Training focuses on how carers are identified, the impact caring can have on health and wellbeing, and support available in the Lothians. 98 sessions were offered throughout 2025/26 and 518 people attended.

To reach as many people as possible in Midlothian and reduce barriers to carer support, VOCAL established a small team of carer support practitioners who provide face-to-face 'drop-in' support. Throughout 2025/26, 136 drop-in sessions were held in GP practices, hospitals, libraries and community hubs as well as locations in rural areas to improve people's access to support.

We want to support carers by providing opportunities to learn new skills, spend time doing the things that matter to them, and bring carers together for peer support. In 2025/26 a series of small grants enabled ten groups to be set up throughout Midlothian specifically aimed at supporting carers to meet new people, learn new skills, and spend time outdoors. These groups also offer peer support opportunities like the Carer Pause group for parents who care for children, and a branch of the Men's Shed in Dalkeith for male carers. Carers who have attended told us that having support close by has made a real difference.

> "Accessing support in my local village has made it possible for me to receive support. Being able to talk to a carer support worker has been life changing, it's the first time I've been able to share how difficult I've been finding things."

It can be difficult for carers to prioritise their own health and wellbeing. VOCAL run a Carer Health Surgery each month where people can book a 45-minute appointment with a nurse practitioner. Since June 2025, over 70% of available appointments were attended by 24 local carers to support them to look after their own health and wellbeing. Throughout 2025/26, VOCAL have also supported 76 carers in over 867 counselling appointments with a trained counsellor, focusing on positive ways for carers to manage their own mental health while caring. Carers told us they appreciate time to focus on their own wellbeing.

"I had been worried about my own health for a while ... I attended a health surgery at VOCAL and it was so reassuring to be able to meet with a nurse and have the time to talk through what was going on. Having time to be able to focus on my own health was so helpful."

Working with our commissioned partners, VOCAL, we have ensured that carers are offered short break grants and funded opportunities to enable carers to take time away from their caring duties. In 2025/26, 344 carers accessed a funded break and a further 402 carers received vouchers or tickets for activities such as day tours, meals out and visits to attractions like wildlife parks, historical sites and gardens.

Opportunities for respite from caring reopened at Highbank Intermediate Care in 2023. These facilities are planned to move to the Midlothian Life Care Facility currently under development at Polton Street. This will include 40 beds with 10 rehabilitation flats, 27 interim care beds, and 3 beds to support respite stays that can be made available to those supported by unpaid carers. A new addition to the facility is the Midlothian Life Health and Social Hub, a staff and service facility hub with other health and social care organisations, information and signposting.

7 Safe from Harm

People using health & social care services are safe from harm.

Scottish Government descriptors for this outcome

- I feel safe and am protected from abuse and harm
- Support and services I use protect me from harm
- My choices are respected in making decisions about keeping me safe from harm.

National Indicators used to measure this outcome

	National Indicator	Our result	Our Progress
9	Adults supported at home agreed they felt safe.		
12	Emergency Admission Rate		
13	Emergency Bed Day Rate		
14	Readmission to hospital within 28 days.		
16	Falls Rate (People over 65)		
17	Care services graded Good or better in Care Inspectorate Inspections.		
20	Health and Care resource spent on hospital stays where the person was admitted as an emergency.		

Indicator 9 is taken from the national Health and Care Excellence Survey (HACE), which is published every two years. As 2025/26 is a reporting year, this indicator has been updated from the 2023/24 data.

This section will be updated in August following the publication of the core suite of integration indicators and the analysis of the Midlothian IJB Annual Survey.

Indicator 9 focuses on the perspective of people receiving support at home, and whether they feel safe within that context. The results are used to assess the quality of care and identify areas where improvements can be made to ensure person-centred care and support.

Some people are more vulnerable and need additional protection from abuse and harm. The Adult Support and Protection (Scotland) Act 2007 provides duties, powers and measures for the support and protection of adults who may be at risk of harm. A range of guidance and services have been developed for vulnerable adults in Midlothian to empower them to suggest improvements to the service. A new advocacy service was launched in early 2026 for those with experience of adult support and protection to share their views on what went well and what could be improved. This includes asking for adaptation when services could be delivered in a different way, providing feedback on whether they felt listened to and their views were respected, and if they felt safer.

Our social work services are a lifeline to people in our communities and ensure people are given the support they need to be safe at home for as long as possible. This includes undertaking the statutory obligation to make inquiries about an adult at risk's well-being, property or financial affairs. This is called the Duty to Inquire.

Support when you need it

A Midlothian resident was referred to Social Work following concerns that their living environment was no longer safe. The case was allocated to a Council Officer to undertake a Duty to Inquire.

The Officer took time to understand what mattered most and the support they needed to make decisions about how ensure their wellbeing at home. Teams worked together to ensure that the right support was available including Council Services, Social Work, Health, Justice Services, Scottish Fire and Rescue and the Third Sector.

As a result, the house was cleared, deep cleaned, new furniture was purchased, a smoke alarm fitted, and garden paths and walkways were cleared to reduce the risk of falls, and ensure it was safe to come and go. The resident told us they were happy with the help received and that their wish to be independent was respected.

In January 2026 the Care Inspectorate visited Newbyres Care Village and reported improvements to medication safety and oversight. Staff have worked to improve processes and safe handling of medicines, including daily checks and recording of medications. The long-term use of medicines to

manage pain can create safety risks, especially in older people. Midlothian Community Hospital has had specialist input from pharmacy colleagues to support people in safely reducing their use of high-risk medicines.

In Scotland, an 'Appropriate Adult' provides vulnerable people aged 16 and over with crucial communication support during police investigations. Appropriate Adults support people over 16 who have a mental disorder as defined by The Mental Health (Care and Treatment) (Scotland) Act 2003 e.g., mental health problems, learning disabilities, Autism, ADHD, dementia, acquired brain injury.

Section 42 of The Criminal Justice (Scotland) Act 2016 requires that the police and agencies ensure the provision of communication support for vulnerable adults in police custody. Appropriate Adults are provided mainly at the request of Police Scotland for people who are being interviewed and who are believed to have a mental disorder. An Appropriate Adult's main roles are to ensures that the persons' rights are upheld, and to provide communication support so that they can understand and be understood. In Midlothian Health and Social Care Partnership, there are 9 trained Appropriate Adults who fulfil this role for those who live in the area. They have worked with 13 people throughout 2025/26 to ensure they are supported and treated fairly throughout the custody process.

We also received feedback on our services in 20 Care Inspectorate Reports across 2025/26. There were a number of areas where the Care Inspectorate told us we were doing well, including wellbeing support, leadership, staff teams and the planning of care and support. Full details of these reports, including the assessment ratings and improvement plans, can be found on page 58.

8 Workforce

Staff are engaged with their work and are supported to continuously improve the information, support, care, and treatment they provide

Scottish Government descriptors for this outcome

- I feel that the outcomes that matter to me are taken account of in my work
- I feel that I get the support and resources I need to do my job well
- I feel my views are taken into account in decisions.

National Indicators used to measure this outcome

These are no National Indicators to measure our progress towards this outcome. We use staff surveys and other local information to evaluate our performance.

Staff experience - iMatter

In the 2025/26 iMatter survey, the Midlothian Health and Social Care Partnership Employee Engagement Index was 78/100. This is the same score as 2024/25. 62% of staff took part in the iMatter survey, which is also the same as the rate in 2024/25 (62%).

The 2025 iMatter Survey highlighted several areas where staff had a positive experience.

- I feel my direct line manager cares about my health and wellbeing
- I am clear about my duties and responsibilities
- I am treated with dignity and respect as an individual
- My work gives me a sense of achievement
- My direct line manager is sufficiently approachable

Our workforce

The workforce is our greatest asset, but we do not directly employ any staff. The health and social care workforce are employed through Midlothian Council, NHS Lothian, and organisations in the Independent and Third sector alongside our unpaid carers and volunteers.

Scottish Government asked us to develop an Integrated Workforce Plan for 2025-28. We consulted with our Partners, staff, Trade Unions, HR, and Finance. The themes that emerged were leadership and management, a nurtured and empowered workforce, training and development, and recruitment and retention.

A draft Integrated Workforce Plan was submitted to Scottish Government on 17th March 2025. We must wait for feedback on this before a publication date can be set. Because Midlothian Health and Social Care Partnership is a Directorate of both NHS Lothian and Midlothian Council there will be overlap between this plan and both the NHS Lothian Workforce Plan and the Midlothian Council Workforce Strategy 2024-34. Our Integrated Workforce Plan 2022-25 can be found on our website.

Staff wellbeing

Working within community settings can be challenging with regular exposure to complex and distressing situations. Psychological issues, including stress, continue to be the primary cause of sickness absence. We want to prioritise ensuring that all staff that work within Midlothian Health and Social Care Partnership are safe and well at work and have continued to fund a Staff Wellbeing Lead post to work alongside staff groups, listen to what matters to them, and provide tailored support.

In 2025/26 Midlothian Health and Social Care Partnership refreshed its Staff Wellbeing, Experience and Engagement Delivery Plan for 2025-2028. This plan focused on the four key drivers designed to improve and maintain staff wellbeing.

- Work has meaning and a positive impact on staff
- Work is a healthy place to be
- We are all able to show leadership
- We listen to staff, and they feel heard.

Managers from within the Midlothian Health and Social Care Partnership have committed to sharing information with staff and being transparent over how decisions are made. We do this by demonstrating visible leadership through developing a schedule of engagement opportunities for senior managers of NHS Lothian, Midlothian Council and Midlothian IJB, and ensuring staff feel involved in decision making with regular feedback opportunities.

One example of this is the Midlothian Health and Social Care Partnership Question Time which is a new initiative in 2025/26. This regular 'Question and Answer' session is with Midlothian health and social care leaders and is an opportunity for staff to explore the issues that matter to them and hear updates on key issues. Questions are collected in advance so the meeting can address popular themes and build connections between staff.

Staff in Midlothian continue to enjoy a monthly lunchtime Soup Stop hosted in the café at Midlothian Community Hospital. These events give staff an opportunity to spent time together, share support, and meet the Executive Leadership Team. Conversations focus on working together and staff wellbeing. In 2025/26 over 250 meals were provided with 25-35 people attending each session.

Our Welbeing support includes education and information sessions and opportunities to learn something new. Midlothian Health and Social Care Partnership encourages all staff to take part in the Staff Network 'Lunch and Learn'. Sessions are held regularly throughout the year and cover a range of subjects from carers rights, menopause and menstrual health, pelvic floor health, disability pride, and neurodiversity.

In 2025/26 we supported the NHS workplace campaign 'Better Informed, Better Choices' to improve staff access to clear, accurate, and timely health information. The project supported staff

to access digital tools and screening information covering topics such as breast and prostate cancer, diabetes, and hypertension.

Reflective Practice sessions are offered to staff to provide an opportunity for continued learning by considering situations they have experienced in their work, exploring outcomes, and improving the quality of their service. In 2025/26, 25 sessions were held and between 10 – 14 people attended each one.

"It was good to have time to listen to each other and find out what is going on for each other."

"I think it helped having someone out with the team facilitating the conversation. It allowed me to participate as an equal."

In recognition of the challenging day to day emotional and physical demands experienced by staff working within the Learning Disabilities team, four bespoke support sessions were delivered at the Cherry Road Centre to encourage teamwork, camaraderie, wellness, and resilience. Quarterly reflective practice sessions are now in place and staff noted the success.

"My coach offered me a different way to look at things and made me think about giving consideration to my own needs. I left the meetings with next steps in place, which I wouldn't have achieved by myself."

"The coach was a great listener and calming to talk to."

One to one Wellbeing Support and Coaching provided by the staff Wellbeing Lead can help staff take a step back and think about how to care for their own health and wellbeing. During 2025/26 over 25 individual and group sessions were offered to staff in Midlothian.

National Workforce Wellbeing Week took place in the first week of September and Midlothian Health and Social Care Partnership hosted 5 sessions with over 200 members of staff coming together to have meaningful conversations about wellbeing within the workplace. Topics focused on how to use cognitive behavioural approaches to manage stress, recognising and managing menopause, and mindful movement and meditation. To mark the end of National Workforce Wellbeing Week, an event was held at Midlothian Community Hospital supported by Midlothian Council, NHS Lothian, and the Third Sector. The event was attended by over 60 staff. who joined in team building exercises, e-bike rides, a silent disco, and hand massages. Feedback was overwhelmingly positive and when staff were asked if they would attend a future National Workforce Wellbeing event, 98% said yes.

On November 6th 2025, Occupational Therapy colleagues, Therapy Support Workers and Community Care Assistants from across Midlothian Health and Social Care Partnership met to mark National Occupational Therapy Week. This was an opportunity for staff to meet face to face and connect with professionals they often only speak to virtually. The day was spent sharing experiences, learning from one another, and celebrating the vital role occupational therapy plays in helping people live meaningful lives. 32 people attended the event, and the impact as described by the attendees was “transformative, meaningful, person-centred and empowering”.

Everyone working across health and social care has an important contribution to positive and healthy working environments. Midlothian Community Hospital were offered a programme of support for staff to learn about each other, share thoughts and ideas, and appreciate differences. Four consecutive weekly sessions were provided and a range of staff attended, with positive feedback reported.

> “The sessions were very relaxing and very eye opening how we handle situations mentally and physically, also making us realise how much we overthink things we cannot control, it brought us all together and gave us a reason to listen to one another."

We continue to prioritise working closely with our NHS Lothian and Midlothian Council Partners to develop skills and knowledge of all staff working within Midlothian Health and Social Care Partnership. In the last year, the Learning and Development team delivered and coordinated more than 1000 learning opportunities, from SVQ programmes (Levels 2, 3 and 4) to Adult Support and Protection, Foundation and Modern Apprenticeships, Child Protection, Team Teach, Trauma Informed Practice, Motivational Interviewing, Dementia Awareness and Medication training. Staff have also accessed post-graduate courses through Edinburgh and Stirling Universities, The Open University, and Napier University.

In line with the experience across health and social care nationally, recruitment and retention continued to be a challenge for Midlothian Health and Social Care Partnership. Areas where this has been particularly challenging is recruiting to Social Worker posts, and ongoing staff vacancies within Highbank Intermediate Care Unit, Care at Home, and Newbyres Care Village.

The Third Sector plays a significant role in Midlothian by working alongside health and social care services to help vulnerable people, support services and encourage a sense of community. In Midlothian there are approximately 30 000 volunteers working with over 500 formal groups or voluntary associations, including sports clubs, uniformed youth groups (e.g. Brownies and Scouts) and small special interest groups such as art clubs and history societies. In addition, there are 270 registered charities and 73 social enterprises. We work also work closely with the Midlothian Third Sector Interface through the Board and committee meetings, and support the Third Sector Summits held in May and October 2025.

On 25th May 2025 volunteers from across Midlothian arrived at Newbattle Abbey College for the annual Midlothian Volunteer Awards Ceremony. This celebration is part of the national initiative, Volunteer's Week, and Midlothian Health and Social Care Partnership sponsors the Health and Wellbeing and Active Volunteer Award at the ceremony each year.

9 £ Use of Resources

Resources are used effectively and efficiently.

Scottish Government descriptors for this outcome

- I feel resources are used appropriately
- Services and support are available to me when I need them
- The right care for me is delivered at the right time.

National Indicators used to measure this outcome

	National Indicator	Our result	Our Progress
4	Adults supported at home agreed that their health and social care services seemed to be well coordinated.		
12	Emergency Admission Rate		
15	Proportion of the last 6 months of life spent at home or a community setting.		
16	Falls Rate (People over 65)		
19	The number of days people aged over 75 spend in hospital when they are ready to be discharged.		
20	Health and Care resource spent on hospital stays where the person was admitted as an emergency.		

Indicator 4 is taken from the national Health and Care Excellence Survey (HACE), which is published every two years. 2025/26 is a reporting year and so this indicator has been updated from 2023/24 data.

This section will be updated in August following the publication of the core suite of integration indicators.

We are responsible for an integrated budget that we receive from Midlothian Council and NHS Lothian. The priorities set out in our Strategic Plan guide how we allocate the money we receive. The Midlothian IJB Medium-Term Financial Strategy supports the monitoring of financial activity and planning. Midlothian Health and Social Care Partnership use the money allocated to services to plan, deliver, monitor, and evaluate the services it provides and commissions. In 2025/26, Midlothian Council and NHS Lothian supported us with the best funding offer they could, but it was not enough to keep pace with the health and social care needs of our people and community. We worked with Midlothian Health and Social Care Partnership to transform services in Midlothian and address local financial challenges.

Our transformation priorities for 2025/26 were set out in our Directions 9.3.1 to 9.3.8. Over the course of 2025/26 we learned that we had asked Midlothian Health and Social Care Partnership to undertake too many changes at the same time. The ambitious programme of work in combination with 'Business as Usual' service provision and delivering on Financial Recovery Plans meant that we made good progress in some areas and found it more challenging to see change in others.

1. **Direction 9.3.1: Midlothian Council and NHS Lothian will support Midlothian HSCP to ensure people can access well-coordinated, timely and high-quality palliative care, care around death, and bereavement support based on their needs and preferences.** Services that provide palliative care continue to deliver quality care and support and this workstream focused on delivering the ambitions of the national Palliative Care Strategy Delivery Plan 2025 – 2028.
2. **Direction 9.3.2: Midlothian Council and NHS Lothian will support Midlothian HSCP to redesign and ensure the most efficient and effective operational model of bed-based provision.** A Midlothian Community Hospital review redesigned bed-based and community pathways to reduce length of stays and support the Home First principles. Planned Date of Discharge was introduced with a 90% compliance rate and overall lengths of stays reduced. Work also included the progression of the Midlothian Life Care Facility with 40 beds and rehabilitation flats and the completion of the design of the Midlothian Life Health and Social Care Hub. Wider transformational planning and progress have been limited due to operational pressures and the complexity and interrelated components of this workstream. This remans a priority for 2026/27.
3. **Direction 9.3.3: Midlothian Council and NHS Lothian will support Midlothian HSCP to redesign the Home First model of care.** Great progress was made, and a full update was provided to the Transformation and Change Programme Board in November 2025. Staff engagement sessions highlighted improvements that could be made in data collection and process improvement to deliver care more efficiently. Several opportunities for redesign were identified, including triage, screening processes and travel efficiencies.
4. **Direction 9.3.4: Midlothian Council and NHS Lothian will support Midlothian HSCP to undertake a review to scope viable opportunities to change financial flow from acute hospital services to the community designed to sustain and expand general practice, mental health & community services at a local level.** The Midlothian Health and Social Care Partnership Primary Care Strategic Working Group has made progress in this area and identified a number of priority areas for continued improvement.

5. **Direction 9.3.5: Midlothian Council and NHS Lothian will support Midlothian HSCP to undertake a review of commissioning spend and establish a new partner provider model that is closely aligned with the strategic aims of the IJB, supports the delivery of key ambitions and increases opportunities for health equality across Midlothian.** A review of commissioned contracts was undertaken and a revised model of Contracts and Commissioning is planned. This remains a priority for 2026/27.
6. **Direction 9.3.6: Midlothian Council and NHS Lothian will ensure that the Midlothian Community Planning Partnership makes best use of the opportunity to bring local public bodies together with local communities and local community partner organisations to effectively strategically plan, design, and deliver service offers that make a real difference in people's lives.** The Community Planning Partnership "Midlothian Will Be Healthier" group was reconvened, and work undertaken with a range of stakeholders to agree priorities for 2026. Planning has also commenced to prepare for the new Single Midlothian Plan.
7. **Direction 9.3.7: NHS Lothian and Midlothian Council will support Midlothian HSCP to improve the experience of people in Midlothian with Dementia by ensuring everyone with a diagnosis of dementia can be offered Post-Diagnostic Support for the first year of their diagnosis and has access to 8 Pillars Model of Community Support.** Great progress was made in 2025/26 with plans for 2026/27 to implementing the Midlothian Health and Social Care Partnership Dementia Framework. Work includes reviewing accommodation options for long-term patients, access to services, and ensuring a consistent service approach.
8. **Direction 9.3.8: Midlothian Council and NHS Lothian will support Midlothian HSCP to review and improve both the system flow, and the experience of people seeking information and seeking support from integrated services by telephone, electronic communication, or written communication.** Transformational planning and progress have been limited due to operational pressures. This work is at an early stage, but the ambition is to provide clear, simple and consistent access to care. This remains a priority for 2026/27.

We listened to the services undertaking the design and delivery of this work and recognised that delivering services day to day, executing financial recovery plans, and leading on transformation was a big ask. Our Directions for 2026/27 have taken this into account and we have aligned this work without financial recovery actions in a more focused approach.

Next steps for Transformation

In our Directions for 2026/27, we have asked Midlothian Council and NHS to support Midlothian Health and Social Care Partnership to focus on three areas of transformation.

Direction 9.3.2	Bed based provision, to enable people to access appropriate levels of care when their needs change.
Direction 9.3.5	Commissioning and Third Sector, to undertake a review of commissioning spend and establish a new partner provider model.
Direction 9.3.8	Midlothian Single Point of Access, to design and implement a method to support people's contact across different health and social care services.

Our hosted services

We plan for and direct two pan-Lothian hosted services that are managed by Midlothian Health and Social Care Partnership. These are Dietetics and the Adults with Complex and Exceptional Needs Service (ACENS) who deliver care to people across the whole Lothian region for the four Health and Social Care Partnerships; Midlothian, East Lothian, West Lothian, and City of Edinburgh.

Dietetics Service

Adult Acute

Adult Acute Dietetic team support people who are in hospital and are at risk of malnutrition and provide advice and support to people with complex nutritional care needs before being admitted to hospital. Nutrition plays a crucial role in acute care and cancer care as nutrition is an important part of recovering from operations and can help people leave hospital and return home more quickly.

In 2025/26, the team introduced a nutritional screening pilot to help lower the impact of surgical stress, reduce lengths of stay in hospital, and contribute to positive outcomes of treatment and support. This work has led to improvements in a number of acute hospital and cancer services:

- Following dietetic assessment, 48% of people who needed a liver transplant were started on Oral Nutritional Supplements (ONS) or had their ONS increased.
- Dietetics support to people with lung cancer led to a 95% confidence level that their length of hospital stay would be reduced compared to those without dietetic input.
- Nutritional support for people with endometriosis and pelvic pain led to significant reductions in ward admissions from a total of 62 over a five-year period to just 3 in 2025/26.
- Nutritional support for people in critical care recovery made significant reductions to length of stay in hospital. At the Royal Infirmary of Edinburgh, length of stay decreased from 16 days to 11.5 days and at the Western General Hospital from 22 days to 18 days.

Paediatric

The Paediatric Dietetic service supports children and young people, as well as their families and carers, in community-based clinics across Lothian. Throughout 2025/26, the service received around 480 new referrals with 80% of those seen in appointments. The dietetic-led coeliac pathway manages 5 – 7 referrals a month and delivers timely support in diagnosing coeliac disease. In 2025/26, the service saved approximately £400 000 by optimising both diagnosis and treatment of cow's milk protein allergies.

Community Enteral Nutrition

The Enteral Feeding Dietetic team supports around 300 adults receiving tube feeding across Lothian. People receive care either in their own homes or in an outpatient clinic, supporting care closer to home and reducing reliance on acute services. The team works closely with Nutricia Homeward service nurses in a collaborative approach that supports patients to remain safely at home, manage tube-related complications in the community, and prevent avoidable hospital

admissions. Recent recruitment initiatives have enabled the team to provide support to the Head and Neck Oncology clinic, with a dedicated dietitian attending appointments once a week.

Intellectual Disability

The Intellectual Disability Dietetic team supports a range of complex health, social and communication needs, including 100 people who receive tube feeding. The team work closely with community nurses, learning disability teams, GPs and social care staff to ensure safe, coordinated and effective nutritional care. The team provides inclusive, accessible education and actively contributes to research activity in the Lothians, including a multi-centre trial evaluating the use of DESMOND education groups adapted for people with an intellectual disability.

Community Gastrointestinal (GI)

The Community GI Dietetic team provide care across the Lothians with a strong emphasis on digital innovation, timely access and patient choice. Face to face clinics are offered at a range of locations, enabling people to be seen close to home, 89% of people who had support from the team in 2025/26 said they were happy with venue of their appointment.

As part of the Irritable Bowel Syndrome (IBS) care pathway, 60% of patients access their first appointment via a video link which reduces travel and supports self-management. At the end of 2025, follow up session that could be requested by patients were introduced and found this helped reduced the number of unnecessary appointments and supported continuity of care.

Community Locality

The Community Locality Dietetic team works alongside patients, their relatives, and carers to manage nutritional needs within the community and helps those with long-term conditions make dietary changes to support rehabilitation and quality of life. The team receives an average of 5154 referrals annually across Lothian, with between 30-50 of these referrals are supported at Midlothian Community Hospital.

Prescribing and Care Home

The Care Homes and Prescribing Dietetic team provides specialist advice and support to all care homes across NHS Lothian. They provide early intervention, safe prescribing, and nutritional care for residents with complex needs. The team are working collaboratively with two GP practices in Midlothian to manage oral nutritional supplement (ONS) and enteral tube feed prescribing and plan to extend this service to more GP practices.

Midlothian Community Respiratory Team

The Midlothian Community Respiratory Dietetic team deliver care for people with chronic obstructive pulmonary disease (COPD) and bronchiectasis and focus on self-management, rehabilitation and prevention of admission to hospital. The team includes physiotherapists, a psychologist and a dietitian who can support early identification of malnutrition and offer prompt treatment. This work has significantly contributed to admission rates to hospital for people from Midlothian with COPD being lower than the national average.

Dietetics and digital

Digital delivery is a critical part of how Dietetics deliver their services and expanding digital and hybrid delivery of care continues to be a focus. Currently, 56% of appointments are delivered via virtual groups and individual assessments, with both Gestational Diabetes and Diabetes Remission offering a fully remote service. Further work is planned to help streamline access to services and triage, increase capacity so more people can receive treatment, and improve pathways so people can easily move between services to get the right support at the right time.

Adults with Complex and Exceptional Needs

The Adult Complex & Exceptional Needs Service (ACENS) provides care across the four Lothian regions for people with exceptional health care needs. The service supports care in a variety of community environments including home and respite settings.

ACENS provides consistent and continuous high-quality care, up to 24 hours a day, 7 days a week, working in partnership with the person and their family, carers and other care giving agencies including the Education and Social Work departments and respite facilities. Many of the people receiving care from ACENS depend on technology to support them live well in their community with a life limiting condition.

The service provides highly specialist care for people in challenging circumstances and also support the families of those being cared for by offering dignified and respectful care that centres on the person and their loved ones.

In 2025/26, the ACENS team were nominated for the Scottish Health Awards in the Integrated Care category. This was in recognition of their compassionate and skilled intervention to support a young person and their family through the transition from paediatric services to adult services during challenging period of health and wellbeing.

How we spent our money (2025/26)

We are funded by our partners, Midlothian Council and NHS Lothian, and are responsible for the integrated budget we receive. This funding is to deliver health and social care in Midlothian.

We work closely with our Partners and receive a budget offer from them both every year. However, we often don't know exactly what this will be until February or March each year. This is because of how our Partners receive funding from Scottish Government.

Financial challenges during 2025/26

We continue to experience financial pressures that reflect both national trends and specific local challenges within Midlothian.

This section will be updated in August following the publication of our draft annual accounts.

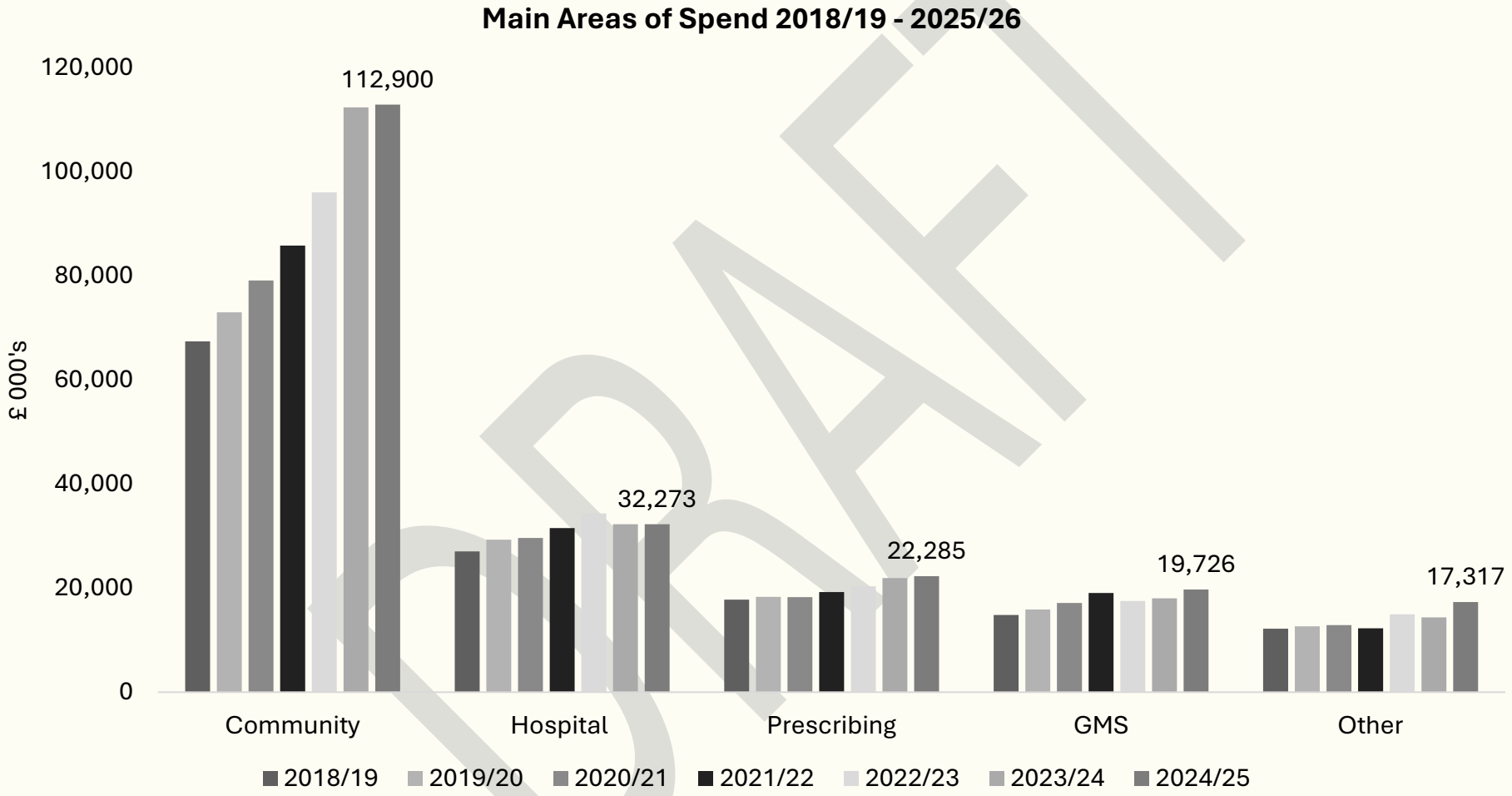
How we spent our money in 2025/26

	Health Budget £000's	Social Care Budget £000's	Health Expenditure £000's	Social Care Expenditure £000's	Variance £000's	Note
Direct Midlothian Services						
Community AHPS						
Community Hospitals						
District Nursing						
General Medical Services						
Health Visiting						
Mental Health						
Other						
Prescribing						
Resource Transfer						
Older People						
Learning Disabilities						
Mental Health						
Physical Disabilities						
Assessment & Care Management						
Social Care Other						
Midlothian Share of Pan Lothian						
Set Aside						

	Health Budget £000's	Social Care Budget £000's	Health Expenditure £000's	Social Care Expenditure £000's	Variance £000's	Note
Mental Health						
Learning Disabilities						
GP Out of Hours						
Rehabilitation						
Sexual Health						
Psychology						
Substance Use						
Allied Health Professions						
Oral Health						
Hosted Other						
Dental						
Ophthalmology						
Pharmacy						
Sub Totals						
Partner Additional Contributions						
Movement in Earmarked Reserves						
Per Annual Accounts						

Main Areas of Spend (2018/19-2025/26)

The graph below compares our spend trends for the past 8 years. We are unable to report on spend by locality as we do not hold data in this form.



Communication and Engagement

We have worked with local people throughout the year to help us understand what is working well, where we can improve and how we can do better. Some examples across 2025/26 include:

This section will be updated in August following the analysis of the Midlothian IJB Annual Survey.

Self-Evaluation of our community engagement

We used the Healthcare Improvement Scotland Quality Framework for Community Engagement and Participation and Self Evaluation Tool to consider how well we were working alongside people and communities, and the impact of this on strategy development and service improvement.

We used the quality indicators within the Framework to recognise what was already working well and identify opportunities for improvement. We concluded we had areas of strength in 'Involvement of people in service planning, strategy and design', and that we were improving in areas of 'Governance and leadership'. We also identified 'Ongoing engagement and involvement of people' as an area for improvement.

In October 2025 we published our Midlothian IJB Participation and Engagement Statement 2025-2028 which outlines the action we will take across 2025- 2028 to improve how we work alongside people and communities in Midlothian.

Living Well In Midlothian annual survey

In spring 2026 we launched our second annual survey and invited people living in Midlothian to complete a questionnaire to share their views about health and social care. We asked people about their health and wellbeing, getting the help and support they need, providing help and support to others, help with everyday living, health conditions and illnesses, and community and services. We took a similar approach to the national Health and Care Experience Survey, using validated questions, to help us better understand local people's experience, focus on opportunities for learning, and identify areas for action.

Unpaid Carers Strategy 2025-2028

As we developed our Unpaid Carer Strategy, we listened to local unpaid carers about the roles they undertake and their experience as carers. This helped us to understand what they can contribute, the impact of caring on them, the support they need to continue, and how we can help support them to have a life of their own alongside their caring role. We also listened to the workforce and our commissioned partners. We researched and listened to carer experiences, including how people were identified as a carer, how they accessed support and felt supported, the impact on their finances and employment, carer wellbeing and having a break from caring, and being involved in decisions about their own care and plans for the person they care for.

There were three main pieces of consultation that informed the Strategy:

1. In-person staff workshop in May 2025.
   This workshop included 26 members of staff from the Third Sector, Midlothian Council and Midlothian Health and Social Care Partnership
2. In-person Carers Action Midlothian meeting in October 2025.
   We spoke to 5 carers and 2 members of staff from our commissioned partner, VOCAL.
3. Online public survey in across November and December 2025.
   34 people gave feedback on our draft strategic priorities.

In all the conversation we had with carers and staff, there was strong support for the draft priorities and a shared desire for change in how services connect, communicate, and respond. The most urgent needs were identified as the need for a single point of contact, better navigation support, early and proactive identification, accessible and consistent information, financial support and employment flexibility, replacement care to make breaks possible, and meaningful involvement at all transition points.

Midlothian Health and Social Care Partnership Engagement

Advocacy Strategy

Midlothian Health and Social Care Partnership ran a lived experience engagement process to inform the development of the Midlothian Health and Social Care Partnership Independent Advocacy Strategy 2026–2029.

The focus was on gathering views from individuals with a statutory right to independent advocacy under the Mental Health (Care and Treatment) (Scotland) Act 2003. A variety of approaches were used to reach adults with mental ill health, adults with learning disabilities, older adults with mental ill health, and young people with disabilities. These included a digital survey, three focus groups, and one to one conversations. Third Sector and independent advocacy providers played a key role in supporting participation and building safe, accessible opportunities for people to contribute.

Four key areas were explored: awareness, accessibility, effectiveness, and priorities for the future of independent advocacy. A digital survey in 2025 gathered 25 responses which told us people value independent advocacy, but it is not always easy to understand or access. Collective independent advocacy also matters as it helps people work together, shape services and support one another. People said it gave them confidence, connection and a real voice in decisions that affect them. Midlothian Health and Social Care Partnership have made a commitment to ensure more people in Midlothian have access to advocacy and can get advice and support to stay well.

Adult Support and Protection (ASP)

Adult Support and Protection Case Conferences (ASPCC) are multi-agency meetings where services from social work, police, and health discuss plans to offer support to an adult who is at risk of harm under the Adult Support and Protection (Scotland) Act 2007. The adult at risk is invited to attend the

ASPCC and is offered advocacy and support. Midlothian Social Work is currently developing a process where adults who have been to an ASPCC are offered an opportunity to provide feedback on their experiences with first contact, assistance during a case conference, and the difference the support made to their care. A form has been reviewed and is now in use for people to give feedback via a paper or electronic copy, or on the phone with the Health and Social Care Practitioner within the ASP Team. Work is ongoing to embed feedback in our planning and ensure that the feedback gathered is meaningful.

Community Justice

Midlothian's Community Justice Partnership coordinated a consultation survey from 7th July to 17th August 2025 to inform service design and delivery. There were 9 main survey questions, and 285 responses were received. When people were asked what Midlothian's Community Justice Partnership could do better, respondents most commonly said they wanted awareness of the service to improve, and that services are kept relevant to reflect the specific needs of Midlothian. People also wanted to be kept up to date with community justice updates digitally through social media and website updates. People were also positive about the role services play in Midlothian communities.

> "Women's Aid and Children's First I feel are one of the best services in Midlothian. I feel they communicate well together, have a great understanding that not everything is black and white, and have other knowledge of access to help within the community."

Trauma Awareness Week

Between the 15th and 19th of September, Midlothian Health and Social Care Partnership organised a week of face to face and online events and webinars to share feedback and lived experience on how to support people with trauma. 58 people attended the in-person launch on Monday September 15th and the event focused on collaboration, with presentations from East and Midlothian Women's Aid, Midlothian House Project, Play Therapy Base, and Midlothian's Trauma Informed Practice Steering Group. A further 91 people joined webinars throughout the rest of the week and discussions focused on subjects like trust, safety, empowerment and choice. Feedback was overwhelmingly positive and participants shared that they felt confident to put their learning into practice.

> "The events have all been excellent and certainly have people talking and thinking about the impact of trauma, which we all know is important."

Consultation on supporting and promoting Gaelic in Midlothian 2026-2031

In the 2022 Scottish census, 0.6% of the Midlothian population identified themselves as Gaelic speakers with 365 individuals speaking, reading and writing Gaelic. Midlothian Council conducted a public consultation on supporting and promoting Gaelic in the local area between November 2025

and January 2026. The consultation was designed to help Midlothian Council deliver their Gaelic Language Plan 2026-2031 which aims to increase opportunities for the community to engage with Gaelic, support the sustainability of Gaelic education (GME) and progress Gaelic Learner Education (GLE), and increase the visibility of Gaelic resources and materials. The results of the consultation were not available at the time of this report.

Equality

We ensure equality is at the heart of what we do. This includes how we make decisions and spend money, the way we work alongside people and communities, and how we improve our services.

Protected characteristics are aspects of a person's identity that are protected by law under the Equality Act 2010. These include age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation. We must work towards ensuring everyone receives fair and equal health and social care.

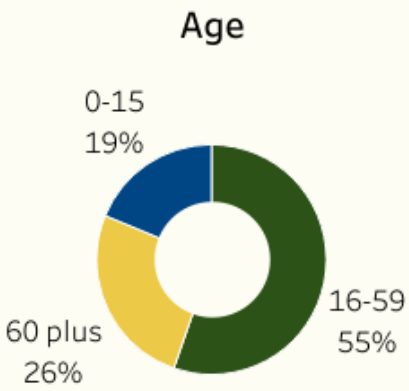
Midlothian has a unique population with its own specific health and social care needs. We use data from the National Census to understand the profile of the people who live in Midlothian and how their access to health and social care may be affected.

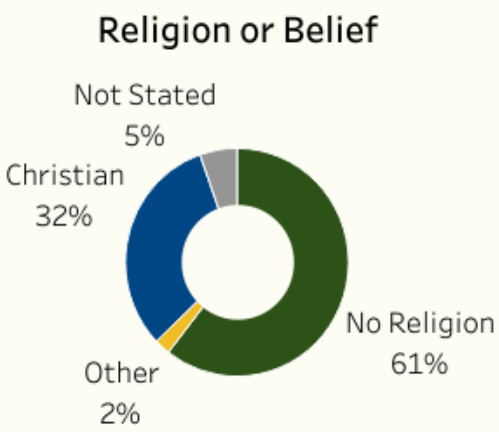
In Midlothian, Equality and Children's Rights Impact Assessments (ECRIAs) are completed to consider how our decisions might impact on people with protected characteristics and advance equality where possible.

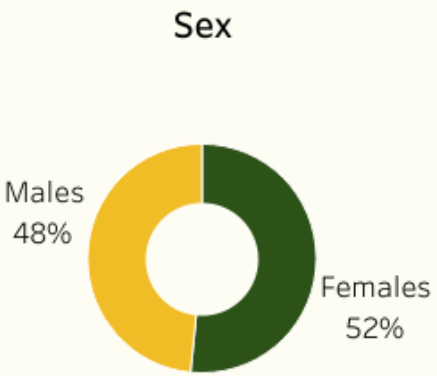
We completed 9 Equality and Children's Rights Impact Assessments for the following new or revised strategies, policies and plans, provisions, practices, and activities:

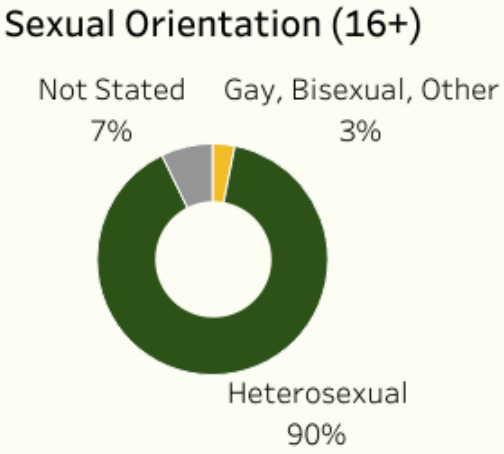
1. Midlothian Integration Joint Board Participation and Engagement Statement 2025-2028
2. Midlothian Integration Joint Board Strategic Plan 2025-2035
3. Midlothian Integration Joint Board Unpaid Carer Strategy 2025-2028
4. Midlothian Integration Joint Board Financial Recovery Plan Commissioning 2025-2026
5. Midlothian Integration Joint Board Financial Recovery Plan Bed Base 2025-2026
6. Midlothian Integration Joint Board Financial Recovery Plan Commissioning 2025-2026
7. Midlothian Integration Joint Board Financial Recovery Plan MCH Bed Base Review 2026-2027
8. Midlothian Integration Joint Board Financial Recovery Plan Care at Home 2026-2027
9. Midlothian Integration Joint Board Financial Recovery Plan Learning Disability 2-1 and Sleepovers 2026-2027.

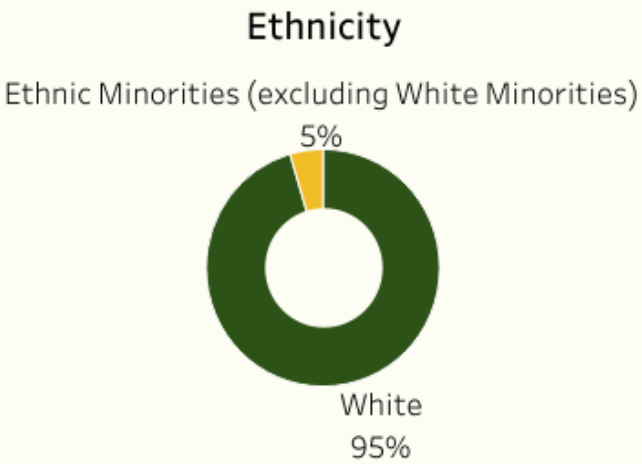
Protected characteristics in Midlothian

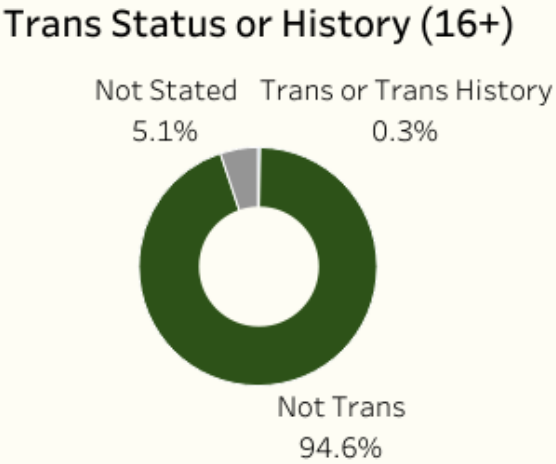












Update on our Equality Outcomes

2025-2029 Mainstreaming Equality Update

Our **Equality Outcomes 2025-2029** set out the actions we would take to advance equality in Midlothian.

To comply with our Public Sector Equality Duty, we must provide an update every two years on what we have done to address equality issues in Midlothian. As part of our ambition for equality to be central to our planning, delivery, reporting and evaluation, we have provided an update on our activity for 2025-2026 in this report and will continue to report on progress every year.

We are working towards making equality part of our day-to-day work and our mainstreaming outcomes support everyone with each of the protected characteristics. Our 4 specific equality outcomes in this report do not cover every protected characteristic but are chosen as they link closely to the aims in our Strategic Plan 2025-2035, and people told us they were important to them in our consultation:

Outcome 1: People have a choice about how they access information and support from integrated services.

Actions: We have reviewed our publicly available information to ensure it is compliant with our duties relating to accessibility and is accessible both on and offline. Everything published by the IJB during 2025/26 has been checked and is compliant with accessibility policies.

We collected feedback that we can use to continuously improve the information we provide. Several services have used feedback to improve how they share information:

1. Midlothian Community Hospital designed an information board to be installed at reception to assist families of those in care to navigate the hospital,
2. A number of staff were offered weight stigma training that was designed based on individual feedback on how people felt they were treated due to their weight, and
3. STRIDE, a program designed to help men who had contact with the Justice service manage their emotions, coproduced a leaflet with people with lived experience to raise awareness of the service.

Outcome 2: People who want to choose Self Directed Support have better information about which option is right for them.

Actions: We have asked Midlothian HSCP to adopt our 'Writing for Publication Style Guide' to ensure all service information is person-centred and meaningful from the perspective of those it is intended to support. A revised version of the guide was published in January 2026 and is accessible for all staff.

We have developed consistently presented online and paper service information, and link with both Partner's websites and information. There is an ongoing program to review and improve these links.
We have ensured that staff can support people to request and access accessible information. We did not receive any requests for information in an alternative format in 2025/26.

Outcome 3: Older people have a reduced risk of admission and readmission to hospital.

Actions: We have improved the data on risk of admission and readmission to hospital to better support clinicians and practitioners to identify and provide appropriate preventative care and early interventions.
We have taken the time to build new relationships and work closely with a range of partners to better coordinate and link redesigned services for people with multiple conditions, including frailty.

Outcome 4: Unpaid carers feel supported to continue in their caring role.

Actions: We have considered the impact of moving care from hospital to home on unpaid carers, and evidence supportive actions. We have published ECRIAs on our transformation plans and this includes consideration for the impact on unpaid carers.
Our Unpaid Carers Strategy sets out the actions we will take to support carers welfare and their ability to provide care for as long as they wish to.
We have ensured that unpaid carers have access to Welfare Benefits advice and that unpaid carers have been offered a Carer Support Plan. We will continue to make sure that carers have access to information on other benefits, grants and financial support that is available to them.

We have asked our Midlothian Council and NHS Lothian Partners to improve the standard of workforce equality data. NHS Lothian delivers an annual Equality and Inclusion Staff Survey to invite staff to share their experiences and opinions. 1670 members of staff across NHS Lothian completed the 2025/26 survey, and responses are being used to support the priorities identified in the Equality and Human Rights Strategy 2023-2028. Midlothian Council are developing a system to record equality information on their workforce system 'iTrent' and are working to raise awareness of why this information is important.

Looking forward

We continue to look to the future. In October 2025 we published our Strategic Plan with a 10-year vision setting out an ambitious but realistic programme of transformation. We have asked Midlothian Health and Social Care Partnership to redesign health and social care as part of a new, sustainable financial model.

Integrated health and social care is changing. This is because of the way our communities are growing, the types of support that people need, and other influencing factors like legislation, national policy, and Scottish Government priorities.

We must balance our decisions with safety, efficiency, and effectiveness, and use opportunities to redesign to deliver a new and sustainable future for health and social care. We know we need to do things differently. The scale of transformation required means we must deliver care and support in new ways.

The Midlothian Health and Social Care Partnership Operational Transformation and Change Programme Board is redesigning a range of health, social and primary care community-based services that are personalised, flexible, and person-led. This work aims to invest in early intervention and prevention, self-management, and education so people make good decisions that help them stay well, plan ahead, and prevent ill or worsening health.

In our Directions for 2026/27, we have asked Midlothian Council and NHS to support Midlothian Health and Social Care Partnership to focus on three areas of transformation.

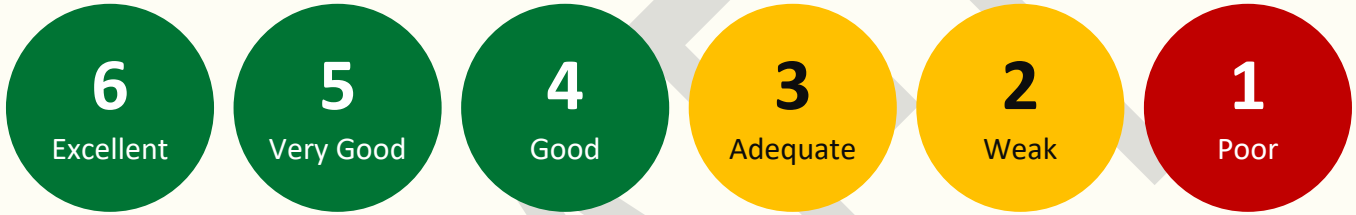
1. Bed based provision, to enable people to access appropriate levels of care when their needs change.
2. Commissioning and Third Sector, to undertake a review of commissioning spend and establish a new partner provider model.
3. Midlothian Single Point of Access, to design and implement a method to support people's contact across different health and social care services.

We have also agreed two strategic financial priorities for effective financial planning and reporting.

1. **We use a new financial evaluation framework to monitor our financial performance in a dynamic and changing system**. We use System Thinking to design new feedback loops that help us make good decisions as health and social care transforms, use financial forecasting to plan ahead and anticipate change, and take corrective action when our funding decisions are no longer helping us achieve our priorities.
2. **As the system changes and transforms, we are confident we are investing in the right places to deliver change in the shortest time possible.** We have effective feedback loops that describe the financial position as the system transforms, identified where investment will make the biggest impact, and evidence how we are delivering care and support more efficiently and effectively.

Inspections

The Care Inspectorate inspect care homes and care at home services to check the quality of care. The majority of care homes in Midlothian are not managed by the Health and Social Care Partnership. Read the full reports at the **Care Inspectorate** website.



Care at Home – Support Services

Name	Date	People's wellbeing	Leadership	Staff team	Setting	Care & support planning
CC Homecare Ltd Support Service	September 2025	**5**	**5**	**5**	Not assessed	**5**
Call-In Home Care West Lothian Support Service	October 2025	**4**	**3**	**4**	Not assessed	Not assessed
Tanshe Care Services	October 2025	**4**	Not assessed	**4**	Not assessed	**4**
J R Care Community Services	February 2026	**3**	**2**	**2**	Not assessed	**3**

Recommendations and Areas for Improvement (if any)

Name	Recommended Improvement
Call-In Home Care West Lothian Support Service	• To ensure people's health and the wellbeing of staff and people, the provider should ensure that quality assurance and leadership tasks are prioritised by managers. This should include, but not be limited to, ensuring that managers are not regularly delivering direct care and support, to enable staffing and quality assurance processes to be completed.
Tanshe Care Services	• The service should ensure that they develop contingency planning in order to anticipate and respond proactively to adverse circumstances which might impact on care delivery. • The service should ensure that staff working with people with complex stress and distressed presentation have undertaken training which supports safe and effective care delivery. • Service reviews should be convened at a minimum of six-monthly intervals, or as and when people's needs change. Review should place a greater evaluative focus on the outcomes arising from care delivery. • Personal plans should be maintained and accurately reflect people's circumstances. The author of the personal plan should be clearly indicated. • Where risk is identified, there should be a clear risk management response, in order to guide staff and promote effective care outcomes.
J R Care Community Services	• By 14 April 2026 the provider must ensure people have confidence that the service they use is led well and managed effectively. To do this, the provider must at a minimum: a) The management have effective oversight of the day-to-day delivery of care to service users to ensure their care needs are fully met. b) The management have a visible presence within the service and engage with service users, relatives and staff to support the development of management oversight required. c) The management engage in a meaningful way with service users and staff about the quality of the service and take action to address improvements identified, to ensure improved outcomes. • By 10 March 2026, the provider must ensure all staff employed within the registered service in roles that fall within SSSC regulated categories are registered with the Scottish Social Services Council (SSSC). To do this, the provider must at a minimum: a) Verify that all staff who require SSSC registration hold an active registration or have submitted an application within the required timeframe. b) Maintain accurate and up to date records of each employee's registration status, renewal dates, and conditions of practice. c) Monitor ongoing compliance, including ensuring staff complete required post registration training and

Name	Recommended Improvement
	learning. d) Notify the SSSC of any concerns. • By 14 April 2026, to ensure people experience high quality care and support delivered by a competency, confident and well supported workforce, the provider must ensure that all staff receive regular, planned and recorded supervision, appropriate training which is assessed for learning outcomes with ongoing observations of practice. To do this, the provider must at a minimum: a) Implement a structured supervision system that ensures all staff receive supervision at the frequency stated in the service's own policy. b) Ensure supervision records are completed, stored appropriately, and demonstrate reflective discussion, identification of learning needs, and follow up actions. c) Develop and maintain an Up To Date training matrix, that clearly shows mandatory, refresher and role specific training, including due dates and completion status. d) Ensure all staff complete mandatory training within expected timescales, and that training is evaluated for effectiveness. e) Introduce a planned programme of direct observations of practice, carried out by suitably skilled senior staff, with written records that identify strengths, areas for development, and agreed actions. f) Use information from supervision, training and observations to inform ongoing workforce development and to ensure staff practice meets expected standards.

Care Homes for Older People

Name	Date	People's wellbeing	Leadership	Staff team	Setting	Care & support planning
Nazareth House	July 2025	**3**	**4**	**4**	**3**	**4**
Pittendreich Care Home	September 2025	**3**	**4**	**4**	**3**	**4**
Springfield Bank Nursing Home	September 2025	**4**	**4**	**4**	**4**	**4**
Nazareth House	November 2025	**3**	Not assessed	Not assessed	**3**	Not assessed
Newbyres Care Village	January 2026	**4**	**3**	**4**	**4**	**4**
Aaron House Care Home	February 2026	**4**	Not assessed	**5**	**4**	Not assessed
Archview Lodge Care Home	February 2026	**4**	**5**	Not assessed	**4**	Not assessed

Recommendations and Areas for Improvement

Name	Recommended Improvement
Nazareth House	• Hand hygiene practices among people receiving care are consistent, particularly for those with cognitive or physical challenges. • Establish scheduled hand hygiene support led by staff, prioritising mealtimes, and toileting routines. • Place clear, user-friendly signage near hygiene stations to encourage good technique and independence. • Increase availability of hand sanitiser in communal areas and ensure residents are encouraged and assisted in using it appropriately. • Reviewing and updating cleaning protocols to reflect the latest standards, with targeted attention to high-touch surfaces and communal areas. • Establishing and maintaining a robust cleaning schedule with clear roles and responsibilities, regular monitoring, and documented evidence of completion. • Delivering continuous training and supervision for domestic and care staff on effective cleaning practices, including correct usage of cleaning products and equipment. • Conducting regular environmental audits to assess standards of cleanliness, with prompt and responsive action taken when improvements are identified. • Oversight must be in place from the management team.
Pittendreich Care Home	• To ensure people experience high quality care, the provider should enable opportunities for staff to reflect on their practice through discussions at team meetings and through regular supervision with their manager. • Skin and wound care was being monitored through clinical overviews however, evidencing and recording of checks and treatment plans needed to be improved upon. There must be a system in place that is able to demonstrate that the skin care needs of those residing in the home are regularly assessed and adequately met. • A refurbishment plan was now in place. Refurbishment work had commenced however, this was still in the early stages, with significant work remaining. The manager needed to ensure the onsite maintenance team clearly understood their roles and responsibilities in relation to ongoing maintenance and repairs of the building. • Personal plans did not consistently give detailed information regarding people's health and wellbeing. This

Name	Recommended Improvement
	included personal care, oral care, food and fluids. Whilst staff appeared attentive to people's needs and knew them well, records should accurately reflect the care given as described in the personal plan.
Springfield Bank Nursing Home	• The provider should ensure that there is a structured support and supervision system in place for staff which incorporates observations of practice in a variety of areas including but not limited to moving and handling, medication, infection control, and stress and distress. This is to support the ongoing development of staff, ensuring they are competent, skilled and able to reflect on their practice to continue to meet people's needs.
Aaron House Care Home	• In order to promote activity and independence for people living in the service, the provider should have appropriate signage around the home. The use of the King's Fund Environmental Assessment Tool and involving people/their representative in designing the environment is recommended to help ensure that best practice and people's needs and wishes are taken into account.

Care Homes for Adults with Learning Disabilities

Name	Date	People's wellbeing	Leadership	Staff team	Setting	Care & support planning
Dougall Court Care Home Service	September 2025	**4**	Not assessed	Not assessed	**3**	Not assessed
Drummond Grange Nursing Home	October 2025	**5**	Not assessed	**5**	**4**	**5**
Parkside Court	February 2026	**5**	Not assessed	**5**	**3**	Not assessed

Recommendations and Areas for Improvement

Name	Recommended Improvement
Dougall Court Care Home Service	• The manager should prioritise advancing plans to explore refurbishment of the home, or alternative options as previously outlined, and ensure that individuals using the service, along with their relatives or guardians,

Name	Recommended Improvement
	are actively and meaningfully involved in shaping decisions about the future of the environment. Clear and realistic timeframes should be established for the completion of all proposed actions.
Parkside Court	• The manager should continue to adapt premises for changing support needs, whilst looking at alternative options as previously outlined, and ensure individuals using the service, along with their relatives or guardians, are actively and meaningfully involved in shaping decisions about the future of the environment. Clear and realistic timeframes should be established for the completion of all proposed actions.

Housing Support Service

Name	Date	People's wellbeing	Leadership	Staff team	Setting	Care & support planning
St Joseph's Services – Circle of Best Practise 1	June 2025	**5**	Not Assessed	**5**	Not Assessed	Not Assessed
St Joseph's Services – Circle of Best Practise 2	June 2025	**5**	Not Assessed	**5**	Not Assessed	**5**
St Joseph's Services – Circle of Best Practise 3	June 2025	**5**	Not Assessed	**5**	Not Assessed	Not Assessed
Midlothian Park Cottage	June 2025	**6**	Not Assessed	**5**	Not Assessed	**6**

Support Service

Name	Date	People's wellbeing	Leadership	Staff team	Setting	Care & support planning
Broomhill Day Centre Penicuik	July 2025	**4**	**4**	**4**	**4**	**4**
The Community Access Team	September 2025	**5**	**4**	**4**	Not Assessed	Not Assessed

Recommendations and Areas for Improvement

Name	Recommended Improvement
Broomhill Day Centre Penicuik	• To ensure people experience high quality care, the provider should enable opportunities for staff to reflect on their practice and identify further learning and development needs through regular supervision with their manager. • To ensure people's outcomes and aspirations are fully achieved, the provider should utilise the sources of evidence from quality audits, discussions with people, staff, and supportive documents to develop a service improvement and development plan.
The Community Access Team	• The service should consult with and determine key stakeholders' views on engagement with quality assurance processes in the service. • Consideration should be given to developing a forum or forums which allow people to share their views and contribute to service development and improvement plans. • The service should develop a training matrix which allows management overview of learning undertaken and insight into when refresher training updates are needed. • The Provider should develop a training matrix which allows management overview of learning undertaken and insight into when refresher training updates are needed • The service should develop competency-based observations of staff practice, clarifying they have the requisite skills and that they put them into practice during support. • Observations should include feedback from people who experienced care and inform discussion, supervision and professional development for the staff concerned.

Business and governance

IJB Membership

Date	Change in membership
June 2025	Val De Souza was nominated and reappointed as the Lead Voting Member of NHS Lothian with effect from 1st August 2025. Dr Rebecca Green was reappointed as a Non-Voting Member of Midlothian IJB with effect from 18th July 2025.
August 2025	Councillor Connor McManus was nominated and accepted as Vice Chair of the Midlothian IJB with effect from 1st July 2025. Val De Souza was nominated and accepted as Chair of the Midlothian IJB with effect from 1st August 2025.
July 2025	Colin Small was nominated and accepted to Midlothian IJB's Strategic Planning Group as a Volunteer Representative with effect from 1st July 2025.
September 2025	Keith Chapman resigned from Midlothian IJB as a Lived Experience Member with effect from 30th September 2025.
October 2025	Jay Johnson was nominated and accepted as a Lived Experience Member of the Midlothian IJB with effect from 1st September 2025. Following her appointment to the post of NHS Lothian Non-Executive Director, Heather Campbell was nominated and accepted as a voting member of the Midlothian IJB with effect from 13th August 2025.
December 2025	Andrew Fleming resigned from Midlothian IJB and as Chair from SPG with effect from 31st December 2025. George Gordon was nominated and accepted as a Non-Executive Board Member of the Midlothian IJB with effect from 1st January 2026.
January 2026	Sheree Muir was nominated and accepted as a Lived Experience Member of the Midlothian IJB with effect from 29th January 2026. Dr Anna Beaglehole was nominated as the named deputy for GP representative with effect from 29th January 2026.

Date	Change in membership
February 2026	Dr Anna Beaglehole's resigned the named deputy for GP representative with effect from 4th February 2026. Dr Paul Bailey was nominated and accepted as a Non-Voting member of Midlothian IJB and specifically as the "registered medical practitioner whose name is on the list of primary medical services performers" with effect from 4th February 2026. Dr Rebecca Green resigned as a Non-Voting Member of Midlothian IJB with effect from 19th February 2026.
March 2026	Jay Johnson resigned from Midlothian IJB as a Lived Experience Member with effect from 1st March 2026.

Key Decisions

Finance

Sep 2025	The Midlothian IJB reviewed and updated the Reserve Policy.
Jun 2025	The Midlothian IJB draft Annual Accounts 2024/25 were approved for publication.
Sep 2025	The Midlothian IJB Annual Accounts 2024/25 were approved for publication.
Mar 2026	The Midlothian IJB approved a balanced budget for 2026/27.

Strategy, Planning, and Performance

Apr 2025	The Midlothian IJB Equality Outcomes for 2025-2029 were approved for publication.
Aug 2025	The Midlothian IJB Annual Performance Report 2024/25 was approved for publication.
Oct 2025	The Midlothian IJB Strategic Plan 2025-2035 and the suite of accompanying documents were approved for publication.
Oct 2025	The Midlothian IJB Participation and Engagement Statement was approved for publication.
Feb 2026	The Midlothian IJB Unpaid Carers Strategy 2025-2028 was approved for publication subject to Midlothian Council approving the section on Young Carers (awaiting).
Mar 2026	The Midlothian IJB Directions for 2026/27 were approved for publication.
Mar 2026	The Midlothian IJB Directions for 2026/27 were issued to the Chief Executives of Midlothian Council and NHS Lothian.

Governance and Audit

Nov 2025	Midlothian IJB received a conclusion of Significant Assurance from Internal Audit in relation to its strategic planning process.
Feb 2026	The Midlothian IJB Meeting Schedule for 2026/27 was approved.
Feb 2026	The Midlothian IJB Standing Orders, Scheme of Administration and Scheme of Delegation were approved for publication.

Other Activity

Mar 2026	IJB Member site visit to Polton Street.

Copies of the relevant reports can be found in the committee reports on the **Midlothian Integration Joint Board** pages of the Midlothian Council website.

Our Strategic Governance Outcome Map – this will be updated after the publication of the core suite of indicators.

What we do	Who with	How they feel	What they learn and gain	What they do differently	What difference this makes
Develop, agree and oversee implementation of a three-year strategic plan	People living in Midlothian and who use our services and their unpaid carers	IJB members feel supported, informed and confident in their role	Assurance that our services are safe, effective, aligned to our strategic priorities and continually improving	People are able to make good decisions that help them stay well, plan ahead and prevent ill or worsening health	Health and Wellbeing: People are able to look after and improve their health and wellbeing and live in good health for longer
Agree and provide clear Directions and associated resource allocation to our LA and NHS partners that are operationally overseen by Midlothian HSCP	HSCP officers, partners and providers			People access the care and support they need when they need it in the community and at home	Living in the Community: People are able to live, as much as possible, independently and at home or in a homely setting in their community
Establish and maintain robust governance arrangements	IJB members		Assurance and oversight on the progress towards achieving our Directions	People's human, social, and economic rights are protected and promoted in how we design and deliver our services	Positive Experiences and Dignity: People who use health & social care services have positive experiences of services, and have their dignity respected
				We transform services to make effective use of resources	Quality of Life: Health &social care services help to maintain or improve the quality of life of people who use them
					Health Inequalities: Health & social care services contribute to reducing health inequalities
					Support for Carers: People who provide unpaid care are supported to look after their health and wellbeing
					Safe from Harm: People using health & social care services are safe from harm
					Workforce: Staff are engaged with their work and are supported to continuously improve the information, support, care, and treatment they provide
					Resources are used effectively and efficiently

Data Appendix

	National Indicator	Our result	Our Progress
1	Adults are able to look after their health very well or quite well.		

Ministerial Steering Group Targets

MEASURE	2021-22	2022-23	2023-24	2024-25	2025-26	STATUS
Maintain emergency admissions into hospital from Midlothian at or below 767 / month.	9,606	8,458	8,263	9,087		
Maintain number of unscheduled hospital bed days: acute specialties at or below 5,074 / month	57,394	60,452	58,123	69,029		
Maintain the use of unscheduled: • geriatric long-stay beds (all ages) • mental health beds (all ages) at or below 2021/22 levels	16,638 11,934	16,747 12,345	14,099P 8,997P	14,604[P] 7,836[P]		
Maintain Emergency Department Attendance (all ages) at or below (2,629 / month)	33,155	33,233	32,453	26,805		
Maintain Delayed Discharge Occupied Bed Days at or below 820 / month.	6,135	12,608	9,627	12,501		
Reduce the percentage of time people spend in a large hospital in their last six months of life.	8%	8.1%	8.2%	No data		
Maintain the proportion of people over the age of 65 who are living in the community at 97% or higher.	96.9%	96.9%	93%	No data		

SOURCE: Public Health Scotland Integration Performance Indicators 2026

*Where noted the calendar year 2025 is used as a proxy for 2025/26 due to the national data for 2025/26 being incomplete. We have done this following guidance from Public Health Scotland. Where noted this data is provisional.